STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315198	A. BUILDING _____ B. WING _____	C 09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

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F 000	INITIAL COMMENTS Complaint #s: NJ00162831; NJ00155894; NJ00165972; NJ001162775; NJ00155713; NJ00152077; NJ00152481; NJ00166081; NJ00165025; NJ00166449 STANDARD SURVEY: 9/6/23 CENSUS: 104 SAMPLE SIZE: 24 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		9/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/19/2023

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide a homelike and dignified dining experience to residents on 2 of 2 nursing units on 3 consecutive days. The deficient practice was evidenced by the following. The surveyor observed the lunchtime meal at the following locations and days/times: Second floor dining room - 8/28/23 at 12:00 PM; 8/29/23 at 12:17 PM; 8/30/23 at 11:57 AM. Third floor dining room - 8/28/23 at 11:45 AM; 8/29/23 at 12:19 PM; 8/30/23 at 12:00 PM.	F 550	F550- RESIDENT RIGHTS / EXERCISE OF RIGHTS I: IMMEDIATE ACTION Place mats were ordered and received to be used on the tables while trays removed. Lids were removed from the tables, collected and placed away from the tables until meal finished Staff in the dayrooms were immediately in serviced on home like dining experience II: IDENTIFICATION OF OTHERS All residents have the potential of being affected by the deficient practice.	

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F 550	Continued From page 2 During each of the observations, staff served residents' meals on plastic trays. The trays remained in place throughout the residents' mealtime. Additionally, staff placed each plate dome lid upside down on residents' tables and used them as a trash container for wrappers and debris from the meal tray. The dome lids remained in place on the tables throughout the mealtime. On 8/30/23 at 12:02 PM the surveyor interviewed the Licensed Practical Nurse (LPN) who supervised the second floor dining room. The LPN stated it was the practice of the facility to leave meal plates on the plastic trays and to leave the dome lids on the table during the entire dining period. On 8/30/23 at 1:26 PM the surveyor told the Director of Nursing (DON) and the Administrator of observed concerns with dining practices that were not homelike or dignified. On 8/31/23 at 10:05 AM the DON stated to the surveyor leaving plates on plastic serving trays and using dome lids for trash was a dignity concern. On 9/6/23 the DON provided the surveyor with the facility Policy and Procedure for Meal Service, last reviewed 1/10/23. The document did not contain information for steps to set up the meal in a dignified and homelike manner. NJAC 8:39-4.1(a)12	F 550	III: SYSTEMIC CHANGES 9/11/23 all dietary and nursing staff were in serviced on home like dining experience 9/11/23 Administrator and Director of Nursing reviewed the policy and procedure for Meal service, updated with the changes IV: QA MONITORING Director of nursing or designee will observe meals in both dayrooms for homelike dining experience weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters All findings will be reviewed at the Quality Assurance meeting x 2 quarters V: PERSON RESPONSIBLE: Director of Nursing, Dietician, Administrator	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		9/11/23

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F 641	Continued From page 3 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete quarterly and comprehensive Minimum Data Set (MDS) assessments in a timely manner for 5 of 23 residents reviewed (Resident #8, #39, #89, #100 and #254). The MDS is an assessment tool used to guide the resident's plan of care. This deficient practice was evidenced by the following: 1. On 8/30/23 the surveyor reviewed the MDS Summary for Resident #8 which revealed the following. The annual MDS indicated an observation end date or assessment reference date (ARD) of Ex.Order 26.4(b). The status of the annual MDS was listed as "in progress."The MDS should have been completed by the 14th day Ex.Order 26.4(b). The MDS was Ex.Ord days overdue on the day of the surveyor's record review (8/30/23). 2. On 8/30/23 the surveyor reviewed the MDS Summary for Resident #39 which revealed the following. The quarterly MDS indicated an ARD of Ex.Order 26.4(b). The status of the quarterly MDS was listed as "in progress." The MDS should have been completed by the 14th day Ex.Order 26.4(b)(1. The MDS was Ex.Ord days overdue on the day of the surveyor's record review (8/30/23).	F 641	I: IMMEDIATE ACTION: MDS (Minimum Data Set) for Resident # 8 with assessment reference date of Ex.Order 26.4(b) Ex.Order 26.4(b) was completed and accepted on MDS (Minimum Data Set) for Resident # 39 with assessment reference date of Ex.Order 26.4(b) Ex.Order 26.4(b) was completed and accepted on MDS (Minimum Data Set) for Resident # 89 with assessment reference date of Ex.Order 26.4(b) Ex.Order 26.4 was completed and accepted on MDS (Minimum Data Set) for Resident # 100 with assessment reference date of Ex.Order 26.4(b) Ex.Order 26.4(b) was completed and accepted on MDS (Minimum Data Set) for Resident # 254 with assessment reference date of Ex.Order 26.4(b) Ex.Order 26.4(b) was completed and accepted on An in service with the MDS (Minimum Data Set) Coordinator was conducted by the Director of Nursing on timeliness and accuracy of MDS completion II. IDENTIFICATION OF OTHERS: All residents have the potential of being affected by this deficient practice. III. SYSTEMIC CHANGES: 9/7/23 an audit was conducted to ensure all residents' MDS (Minimum Data Set) was completed timely, negative findings addressed by the Director of Nursing,	

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F 641	Continued From page 4 3. On 08/28/23 at 11:26 AM, the surveyor observed Resident #89, awake, alert lying in bed, responding to the surveyor by nodding his head. The surveyor reviewed the medical records of Resident #89, which revealed the following: Resident #89 was admitted to the facility on Ex.Order 26.4(b)(1) and readmitted with diagnoses that included but were not limited to Ex.Order 26.4(b)(1) [redacted] The Admission MDS (AMDS), dated Ex.Order 26.4(b)(1) reflected that the resident had a Brief Interview for Mental Status (BIMS) score Ex.Order out of 15, indicating that the resident's cognition is Ex.Order 26.4(b)(1) [redacted] Resident #89 was observed to have an AMDS with an ARD of Ex.Order 26.4(b)(1) and was due to be submitted no later than Ex.Order 26.4(b)(1). The MDS was not submitted until Ex.Order 26.4(b)(1) 4. Resident #100 was admitted to the facility on Ex.Order 26.4(b)(1) with diagnoses that included but were not limited to Ex.Order 26.4(b)(1) [redacted] The AMDS, dated Ex.Order 26.4(b)(reflected that the resident had a BIMS score of Ex.Ord out of 15, indicating that the resident's cognition Ex.Order 26.4(b)(1)	F 641	Administrator and MDS Coordinator. 9/7/23 Policy and Procedure on MDS (Minimum Data Set) was reviewed by Director of Nursing and Administrator, no changes made. 9/11/23 the Regional Nurse conducted an in service with the MDS coordinator, Director of Nursing and Assistant Director of nursing on timeliness and accuracy of MDS completion, also on how to monitor for timely completion IV. QA MONITORING An audit of 10 residents will be conducted by the Director of Nursing or designee to ensure all due in progress MDS (Minimum Data Set) are completed timely, weekly x 4, then monthly x 2 months, then quarterly x 2 quarters. All findings will be reviewed at the Quality Assurance meeting x 2 quarters V. PERSON RESPONSIBLE: Director of Nursing, MDS (Minimum Data Set) Coordinator.	

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F 641	Continued From page 5	F 641		

Resident #100 was observed to have an AMDS with an ARD of Ex.Order 26.4(b)(1) and was due to be submitted no later than 8 Ex.Order 26.4(b)(1) The MDS was not submitted unti Ex.Order 26.4(b)(1)

5. Resident #254 was admitted on Ex.Order 26.4(b). The Comprehensive/5 Day MDS had an ARD of Ex.Order 26.4(b)(1) which was completed late on Ex.Order 26.4(b)(1)

On 8/31/23 at 2:00 PM, a Validation Report was received from the Regional MDS Coordinator which confirmed the comprehensive assessment was completed late.

On 8/31/23 at 2:05 PM, the survey team spoke to the Director of Nursing (DON) and the Administrator regarding late MDS submissions. The DON stated a new MDS Coordinator was hired, however, did not show up for work. A second was hired but has not yet started.

The DON stated a Quality Assurance Performance Improvement (QAPI) was started in April 2023 for the "timely completion of MDS assessments." The DON voluntarily provided information to the survey team regarding the facility's quarterly QAPI meetings and the MDS submission compliance rates.

The surveyors reviewed the facility's QAPI for "Timely MDS Completion/Transmission,"

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F 641	Continued From page 6 reporting period April 2023 to July 2023; reviewed 7/28/23 and 8/23/23; next review date 9/29/23. The April 2023 compliance rate of 95.7% had dropped to 31.2% in July 2023. The DON provided the surveyors with the facility MDS policy on 8/31/23. Procedure #4 indicated "the RN MDS Coordinator monitors the completion of the scheduled assessments including the Care Area assessments, signs and dates when the MDS is completed." NJAC 8:39-11.2(e)	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		9/11/23

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F 656	Continued From page 7 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint # NJ00155894 Based on interviews, review of medical records and other facility documentation, it was determined that the facility failed to develop a comprehensive, person-centered Care Plan (CP) to address the needs for a resident with Ex.Order 26.4(b)(1) [redacted], and that Ex.Order 26.4(b)(1) Resident #104), 1 of 24 residents reviewed for CP. This deficient practice was evidenced by the following:	F 656	IMMEDIATE ACTION Resident # 104 was discharged home Ex.Order 26.4(b) [redacted] 9/11/23 nursing staff received education on development and implementation of comprehensive care plans 9/11/23 an audit of all residents with diagnosis of Diabetes, Epilepsy or oxygen in use care plans were reviewed to identify any care plan deficiencies. All identified care plan deficiencies were immediately corrected.	

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F 656	Continued From page 8 According to the Admission Record, Resident #104 was admitted to the facility in Ex.Order 26.4(b)(1), with diagnoses that included but were not limited to: Ex.Order 26.4(b)(1) [redacted] A review of the Admission Minimum Data Set (MDS), an assessment tool dated Ex.Order 26.4(b)(1), revealed a Brief Interview for Mental Status of Ex.Order 2 indicating Ex.Order 26.4(b)(1). Further review of the MDS revealed the resident was Ex.Order 26.4(b)(1) for activities of daily living, had an Active Diagnoses of Ex.Order 26.4(b)(1) [redacted]. A review of the physician order summary report for Ex.Order 26.4(b)(1) revealed a physician's order for Ex.Order 26.4(b)(1) [redacted] A review of the facility provided CP initiated Ex.Order 26.4(b)(1), revealed a "Focus" for Resident #104;. Ex.Order 26.4(b)(1) [redacted] ate Initiated: Ex.Order 26.4(b)(1)	F 656	II: IDENTIFICATION OF OTHERS All residents have the potential of being affected by this deficient practice III: SYSTEMIC CHANGES On 9/11/23, the policy and procedure on Care Plans was reviewed, no changes. Care plans will be developed and implemented in accordance with facility policy and federal regulations. Care plans will be reviewed and revised in accordance with residents□ changes in condition and circumstance Care plans will be reviewed for any resident on the 24 hour report at daily clinical meeting to ensure that appropriate changes and updates have been made. IV: QA MONITORING Director of Nursing or designee will conduct and audit of 5 residents to ensure all care plans are complete in accordance with facility policy and federal regulation ((including diagnosis of Diabetes, Epilepsy, oxygen use) weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters All findings will be reviewed at the Quality Assurance meeting x 2 quarters V: PERSON RESPONSIBLE: Director of Nursing, Assistant Director of Nursing, Facility Educator	

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F 656	Continued From page 9	F 656		

Further review of the CP, did not reveal a Focus for Ex.Order 26.4(b)(1) [redacted]

On 08/31/23 at 1:21 PM, during an interview with the surveyors, the Licensed Practical Nurse (LPN) stated that the purpose of the CP was to "know" what the resident's goals were and what the resident "was capable of doing." She then stated that the "focus" of the CP was "guided toward" the resident's diagnoses. The surveyor asked the LPN if she would expect to see a CP for a resident with diagnoses of Ex.Order 26.4(b)(1) [redacted], she stated, "yes, they should all be on the CP."

On 09/01/23 at 9:28 AM, during a meeting with the surveyor, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON stated that the purpose of the CP was to "actually meet the needs of the patient and to makes sure the interdisciplinary team, the patient and the responsible party were on same page." The DON stated that it would include the "MDS and medical diagnoses." The surveyor asked the DON and the ADON, if they would expect to see a CP for a resident with diagnoses of Ex.Order 26.4(b)(1) [redacted] they both stated, "yes they should." The surveyor asked the DON and the ADON to review the facility provided CP, for resident #107, for Ex.Order 26.4(b)(1) [redacted]. The DON stated, "sad to say, I cannot find those 3 items." They both confirmed that all 3 of the above items should have been addressed on the CP.

A review of the facility's policy "Comprehensive Care Plan" with a last review date of 2/1/23, revealed:

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F 656	Continued From page 10 Policy Statement: A. A comprehensive care plan for each resident shall be developed and initiated on admission at this facility utilizing and interdisciplinary team approach. The comprehensive care plan will be individualized, defining the problems/needs identified from each discipline's assessment, attainable goals, and interventions. B. The resident's initial comprehensive care plan shall be completed by all disciplines within 14 days of admission. Purpose: A. To provide a system for all disciplines involved to direct resident care to: Identify and assess each resident's problems/needs. Develop, document, and implement a coordinated plan of care. Evaluate the effectiveness of the plan of care and modify plan as needed. N.J.A.C 8:39-11.2 (d) (e) (1) (2) (3)	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure a physician's order for Ex.Order 26.4(b)(1) was complete and thorough for 1 (#254) of 1	F 695	F695 RESPIRATORY I: IMMEDIATE ACTION The Ex.Order 26.4(b)(1) for Resident # 254 was clarified with the Medical doctor to read	9/11/23

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F 695	Continued From page 11 resident reviewed for Ex.Order 26.4(b)(1). The deficient practice was evidenced by the following: On 8/29/23 at 9:30 AM, the surveyor observed resident #254 in his/her room awake, alert, and oriented in bed. The Ex.Order 26.4(b)(1) was turned off and had no tubing or Ex.Order 26.4(b)(1) attached. The water reservoir was dated Ex.Order 26.4(b)(1) On 08/30/23 at 11:53 AM, the surveyor interviewed the resident. The resident was pleasant and interviewable. The Ex.Order 26.4(b)(1) at the bedside was turned off and had no tubing or Ex.Order 26.4(b)(1) attached. On 08/30/23 12:15 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to the resident. The surveyor asked the LPN to review the Ex.Order 26.4(b)(1) with her in the Electronic Health Record (EHR). The LPN showed the surveyor the order which read Ex.Order 26.4(b)(1) 0700." The LPN confirmed the order was incomplete since it did not indicate whether the Ex.Order 26.4(b) was to be used continuously or as needed (prn). A review of the hybrid Medical Record revealed the following information. The Ex.Order 26.4(b)(1) Order Summary included an order for Ex.Order 26.4(b)(1) as follows. - Ex.Order 26.4(b)(1) 0700.	F 695	Ex.Order 26.4(b)(1) " The nurse responsible for entering the incomplete Ex.Order 26.4(b)(1) was in serviced on proper Ex.Order 26.4(b)(1) including frequency. II: IDENTIFICATION OF OTHERS All residents have the potential of being affected by the deficient practice. III: SYSTEMIC CHANGES On 9/11/23 an audit of all resident receiving oxygen was completed, to ensure all orders are complete with the prescribed frequency and care plan updated accordingly. On 9/11/23 an in service for all nurses was conducted on making sure all residents have complete oxygen orders, with the prescribed frequency specified and care plan updated accordingly. 9/11/23 Administrator and Director of Nursing reviewed the policy and procedure for Oxygen use, no changes were made. IV: QA MONITORING Director of nursing or designee will audit 5 residents with oxygen orders to ensure the order is complete with the prescribed frequency and care plan updated, weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters All findings will be reviewed at the Quality Assurance meeting x 2 quarters V: PERSON RESPONSIBLE: Director of Nursing, ADON	

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F 695	Continued From page 12 The respiratory Care Plan initiated on Ex.Order 26.4(b)(1) included an intervention for Ex.Order 26.4(b)(1) [redacted] @ 2 lpm. On 8/30/23 at 1:30 PM, the surveyor interviewed the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Infection Preventionist (IP) regarding the incomplete Ex.Order 26.4(b) order. On 08/31/23 at 10:00 AM, the DON confirmed the Ex.Order 26.4(b)(1) was incomplete. A new Ex.Order 26.4(b) [redacted] was received from the physician on 8/30/23 for 2 lpm as needed for Ex.Order 26.4(b)(1) level. On 8/31/23 the DON provided the surveyor with the facility Oxygen Administration Policy and Procedure with a reviewed date of 10/29/22. The policy reflected that if a resident is using oxygen, the frequency and duration of the treatment should be recorded in the resident's medical record.	F 695		
F 755 SS=E	NJAC 8:39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		9/13/23

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F 755	Continued From page 13 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to a.) accurately obtain a blood pressure and accurately document the site, b.) accurately document the refusal of medications, d.) dispose of medications in a safe manner, c.) clarify and accurately administer a medication (Midodrine) according to a physician's order and d.) remove and dispose of controlled substances from active inventory when discontinued from March of 2023 until surveyor inquiry. The deficient practices occurred for two (2) of seven (7) residents, (Resident #56 and #75) reviewed for medication management and	F 755	I: IMMEDIATE ACTION Resident # 75 was discharged home on Ex.Order 26.4(b) Resident # 56 □s Ex.Order 26.4(b)(1) readings were reviewed, Ex.Order 26.4(b)(1) findings regarding the site for the reading, MD aware of the readings. New vital signs machines were provided to each unit on 8/31/23 A Drug Buster medication disposal unit was placed on all the medication carts on 8/30/23 A medication error report was completed for Resident # 75 regarding the Ex.Order 26.4(b)(1) order not followed on the specified dates.	

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F 755	Continued From page 14 for two (2) of two (2) medication refrigerators inspected. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." This deficiency was evidenced by the following: 1. On 8/30/23 at 8:00 AM, during the morning medication pass, the surveyor observed the Licensed Practical Nurse (LPN #1) obtaining a Ex.Order 26.4(b)(1) for Resident #56. The LPN#1 placed the [redacted] on the resident's [redacted] The LPN #1 stated that this was the best way to obtain the [redacted] because the	F 755	Controlled medications for Resident #88 and Resident # 64 which were previously discontinued, were immediately removed from the refrigerator and disposed as per guidelines. The narcotic boxes in the refrigerators were locked as per guidelines. LPN #1 and LPN #2 were in serviced on vital signs, refusal of medication procedure and documentation, blood pressure parameters (including for Midodrine), controlled medication storage and removal/ II: IDENTIFICATION OF OTHERS All residents have the potential of being affected by the deficient practice. III: SYSTEMIC CHANGES On 9/12/23 an in service for all nurses was conducted on vital signs, refusal of medication procedure and documentation, blood pressure parameters (including for Midodrine), controlled medication storage and removal On 9/12/23 Administrator and Director of Nursing reviewed the policy and procedure for Vital signs, Physician orders, Meds with parameters, Controlled medications disposal, no changes were made. On 9/13/23 an audit was completed for all residents with Midodrine orders, ensuring the order has proper parameters IV: QA MONITORING Director of nursing or designee will audit 5 residents with vital signs orders to ensure the site of the blood pressure reading is correct and appropriate, weekly x 4 weeks	

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F 755	Continued From page 15 resident was Ex.Order 26.4(b)(1). The LNP#1 then stated that she received an error indication on the digital Ex.Orde machine, the surveyor observed her reposition the Ex.Order 26.4(b) on the same area and immediately restarted the Ex.Orde machine. The LNP#1 then stated that she had obtained a Ex.Order 26. and a heart rate Ex.Order 26.4(b)(1). The LPN#1 added that the resident's Ex.Orde was usually Ex.Order 2 and would check the Ex.Orde again later. After removing the Ex.Orde cuff, the LPN#1 asked the resident if he/she wanted the Ex.Order 26.4(b)(1) and the resident shook their head in the "yes" direction. The LNP#1 explained to the surveyor that the resident did not always like the Ex.Order 26.4(b)(1) because it turned the applesauce black and would refuse to take it. On 8/30/23 at 8:07 AM, the surveyor observed the LPN#1 preparing five (5) medications which included one (1) Ex.Order 26.4(b)(1) for Resident #56. On 8/30/23 at 8:16 AM, upon returning to the medication cart, the LPN #1 indicated on the EMAR the Ex.Order 26.4(b)(1) was obtained in the sitting position to the Ex.Order 26.4(b)(1). The LPN#1 stated she had not seen another way to enter the site the Ex.Orde was taken. The surveyor reviewed the medical record for Resident #56. A review of the resident's Admission Record (AR) revealed diagnoses which included Ex.Order 26.4(b)(1)	F 755	then monthly x 2 months, then quarterly x 2 quarters Director of nursing or designee will audit 5 residents with medication refusal to ensure that refusal is documented appropriately and care plan is in place, weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters Director of nursing or designee will audit 5 residents with Midodrine orders to ensure the order is complete with parameters and that the order is followed according to the parameters, weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters Director of nursing or designee will check medication room on both units to ensure the narcotic box in the refrigerator is locked and that there are no controlled medications stored in the box if the order was discontinued, weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters All findings will be reviewed at the Quality Assurance meeting x 2 quarters V: PERSON RESPONSIBLE: Director of Nursing, ADON	

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A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of Ex.Order 26.4(b)(1), reflected the resident had a brief interview for mental status (BIMS) score of Ex.Order 26.4(b) out of 15, indicating that the resident had Ex.Order 26.4(b)(1) .

A review of the Order Summary Report revealed physician orders (PO) dated Ex.Order 26.4(b) for Ex.Order 26.4(b)(1) "

A review of the vital sign recordings for Ex.Orde for Ex.Order 26.4(b)(1) had the following dates which indicated the site for the Ex.Orde was "other"; Ex.Order 26.4 at 7:14 PM, Ex.Order 26.4 at 8:43 AM, and Ex.Order 26.4 at 8:01 AM. All other entries for the site of the Ex.Orde were to the Ex.Order 26.4(b)(1)

A review of the Ex.Order 26.4(b EMAR reflected the above PO and revealed that the vital sign recordings for Ex.Order 26.4 and Ex.Order 26.4 were entered by LPN#1.

On 8/30/23 at 12:13 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the Infection Preventionist (IP) and Assistant Director of Nursing (ADON) were the staff educators for medication pass.

On 8/30/23 at 1:08 PM, the surveyor interviewed the Unit Manager (UM)/LPN who stated that she was familiar with Resident #56 but had not taken a Ex.Order on the resident's Ex.Orde The UM/LPN could not speak to if that was the correct method because she had not taken the Ex.Orde that way. The UM/LPN

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stated that a Ex.Order 26.4(b)(1) had not sounded accurate and would retake the Ex.Order to be sure. The UM/LPN added that when she would retake the Ex.Order that she would change Ex.Order 26.4(b)(1) in order to get an accurate reading. The UM/LPN also stated that she used her own digital Ex.Order machine because there was only one Ex.Order machine on the unit and there were two nurses who would be administering medications at the same time, so it was easier to use her own. At that time, the UM/LPN was unable to locate the facility Ex.Order machine that was on the unit.

On 8/31/23 at 9:30 AM, the surveyor interviewed the IP who stated that she was employed at the facility approximately Ex.Order 26.4(b)(1) and could speak to medication pass techniques because she helped with orientation and educating the nurses on medication pass techniques. The IP stated that a Ex.Order 26.4(b)(1) had not sounded accurate and would recommend retaking the Ex.Order and if the Ex.Order was accurate than the physician should be called. The IP explained that if an error or inaccurate reading of a Ex.Order was obtained then the nurse should retake the Ex.Order. The IP further explained that retaking a Ex.Order would mean changing the site such as going from Ex.Order [redacted] if the same site was going to be used again then the nurse would have to wait at least five (5) minutes because retaking the Ex.Order on the same site could give an inaccurate reading. The IP stated that she would prefer the nurses using the facility Ex.Order machines because they were calibrated and remained in the facility. The IP further stated that when nurses used their own Ex.Order machines there was the possibility that they were not always calibrated and accurate. The IP also stated that she knew there was one Ex.Order machine on each unit and that there were

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additional [redacted] machines that were being purchased.

On 8/31/23 at 11:30 AM, the IP provided the surveyor with a "Medication Pass Audit Tool" dated [redacted] for LPN #1 completed by the Consultant Pharmacist (CP) which revealed that there were areas indicating a "No", which meant that a technique was not performed appropriately.

On 8/31/23 at 2:07 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, ADON and IP. The IP stated that when a medication pass audit was performed if there were indications that proper procedures were not followed then another observation and in servicing would be followed up. The DON stated that she would check if there were any other medication observations performed for LPN #1.

On 9/1/23 at 8:58 AM, the DON provided the surveyor with an "In-service on medication pass" dated [redacted] completed by the ADON and signed by LPN #1 was performed and a "Competency Validation: Medication Pass" was completed by the ADON on [redacted] that indicated the LPN#1 "Meets Standard" for all the "Performance Criteria." In addition, the DON provided a "Medication Observation Form" dated [redacted] for LPN #1 completed by the provider pharmacy which revealed that there was zero (0) % error rate.

On 9/1/23 at 9:38 AM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone who stated that she had been the consultant for the facility for approximately [redacted]. The CP stated that she had performed medication observations with the nurses and verified that she

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used a "Medication Pass Audit Tool" but was unable to speak to the actual form that she had completed for LPN#1. The CP stated that she would add to the form "Discussed "tips & tricks" for med pass observation by Department of Health (DOH), etc." because as she performed the medication observation, she would review different areas to help the nurses understand what the correct procedure that should be done during the medication pass. The CP added that the completed "Medication Pass Audit Tool" was left with the DON and if there were issues, she would review them, and the DON would decide the next step.

A review of the facility policy dated as reviewed 6/22/23 for "Medication Administration and Documentation" provided by the DON reflected that "It is the policy of this facility to ensure that Medication Administration and Documentation occurs in a timely and accurate manner." In addition, "The EMAR is the form onto which all medication orders are transcribed from physician electronic orders, from which medications are poured and administered and on which medication doses are documented."

A review of the facility policy dated as reviewed 3/1/23 for "Vital Signs" provided by the DON reflected that "Vital signs are documented in the medical records. Vital signs can be taken manually or obtained electronically. Physician's or Nurse Practitioner's should be notified about changes in vital signs including any symptoms identified, in accordance with parameters ordered."

2. On 8/30/23 at 8:05 AM, during the morning

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medication pass, the LPN#1 asked the resident if he/she wanted the [redacted] and the resident shook their head in the "yes" direction. The LNP#1 explained to the surveyor that the resident did not always like the [redacted] because it turned the applesauce black and would refuse to take it.

On 8/30/23 at 8:07 AM, the surveyor observed the LPN#1 preparing five (5) medications which included one [redacted] for Resident #56.

On 8/30/23 at 8:14 AM, the surveyor observed the LPN #1 crush four (4) of the five (5) medications together in a pouch and then poured the crushed medications into a 30 milliliter (ML) medication cup with applesauce. The LPN#1 then opened the [redacted] capsule and mixed the contents into the medication cup that had the four (4) medications and filled the medication cup with applesauce. The applesauce then turned a black color.

On 8/30/23 at 8:16 AM, the surveyor observed the LPN#1 approach the resident to administer the five (5) medications in the applesauce and the resident was shaking their head in the "no" direction. The LPN #1 explained that the applesauce contained the resident's medication and that it was important to take the medications.

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The LPN#1 scooped a spoonful of the applesauce and administered the spoonful to the resident. The resident took the spoonful and shook their head in the "no" direction repeatedly. The LPN#1 explained again the importance and told the resident there was just another spoonful left. The LPN#1 was unable to administer the remaining applesauce containing the medications.

Upon returning to the medication cart, the LPN#1 discarded the remaining applesauce and stated that the resident had swallowed more than half of the applesauce, so she felt that the resident had received the medications. The LPN#1 then indicated on the electronic administration record (EMAR) that the resident had received the five (5) medications. The LPN#1 had not documented any refusal of medication by the resident.

The surveyor reviewed the medical record for Resident #56.

A review of the resident's Admission Record (AR) revealed diagnoses which included Ex.Order 26.4(b)(1) [redacted]

A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of Ex.Order 26.4(b)(1) reflected the resident had a brief interview for mental status (BIMS) score of Ex.Order 26.4(b)(out of 15, indicating that the resident had Ex.Order 26.4(b)(1) .

A review of the Order Summary Report revealed

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physician orders (PO) for the following:
Ex.Order 26.4(b)(1) with a start Ex.Order 26.4(b)(1) times a day for Ex.Order 2 -give with food hold if Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) with a start date of Ex.Order 26.4(b).
Ex.Order 26.4(b)(1) with a start date of Ex.Order 26.4(b)(1)
Ex.Order 26.4(b)(1) with a start date of Ex.Order 26.4(b)(1)
Ex.Order 26.4(b)(1) with a start date of Ex.Order 26.4(b).

A review of the Ex.Order 26.4(b)(1) EMAR revealed consistency with the above POs. In addition, the EMAR had not revealed any refusals by the resident for medications.

A review of the resident's progress notes had not indicated that there were any refusals of medications.

A review of the resident's Interdisciplinary Care Plan had not revealed that there was a "Focus" area for the resident refusing medications.

On 8/30/23 at 12:13 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the Infection Preventionist (IP) and Assistant Director of Nursing (ADON) were the staff educators for medication pass.

On 8/30/23 at 1:08 PM, the surveyor interviewed

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the Unit Manager (UM)/LPN who stated that she was familiar with Resident #56 and was unaware of any medication refusals. The UM/LPN stated that when a resident refused medications the physician would be notified and there would be documentation in the progress notes.

On 8/31/23 at 9:30 AM, the surveyor interviewed the IP who stated that she was employed at the facility approximately Ex.Order 26.4(b)(1) and could speak to medication pass techniques because she helped with orientation and educating the nurses on medication pass techniques. The IP stated that the nurses would have to document that a medication was refused because the whole dose would not have been administered and the physician should be notified. The IP also stated that the nurses should try to figure out why the resident was refusing medications and put interventions in place such as changing the medication if the taste were an issue or possibly changing the time.

In addition, the IP provided the surveyor with a "Medication Pass Audit Tool" dated Ex.Order 26.4(for LPN #1 completed by the Consultant Pharmacist (CP) which revealed that there were areas indicating a "No", which meant that the technique was not performed appropriately.

On 8/31/23 at 2:07 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, ADON and IP. The IP stated that when a medication pass audit was performed if there were indications that proper procedures were not followed then another observation and in servicing would be followed up. The DON stated that she would check if there were any other medication observations performed for LPN #1.

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On 9/1/23 at 8:58 AM, the DON provided the surveyor with an "In-service on medication pass" dated Ex.Order 26.4(b) completed by the ADON and signed by LPN #1 was performed and a "Competency Validation: Medication Pass" was completed by the ADON on Ex.Order 26.4(b) that indicated the LPN#1 "Meets Standard" for all the "Performance Criteria." In addition, the DON provided a "Medication Observation Form" dated Ex.Order 26.4 for LPN #1 completed by the provider pharmacy which revealed that there was zero (0) % error rate.

On 9/1/23 at 9:38 AM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone who stated that she had been the consultant for the facility for approximately Ex.Order 26.4. The CP stated that she had performed medication observations with the nurses and verified that she used a "Medication Pass Audit Tool" but was unable to speak to the actual form that she had completed for LPN#1. The CP stated that she would add to the form "Discussed "tips & tricks" for med pass observation by Department of Health (DOH), etc." because as she performed the medication observation, she would review different areas to help the nurses understand what the correct procedure that should be done during the medication pass. The CP added that if a resident was refusing a medication or was unable to receive the entire dose then the physician should be notified, and the nurses should review the possible reason the resident was refusing to possibly make a change. The CP added that the completed "Medication Pass Audit Tool" was left with the DON and if there were issues, she would review them, and the DON would decide the next step.

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A review of the facility policy dated as reviewed 6/22/23 for "Medication Administration and Documentation" provided by the DON reflected that "Documents administration of medication in the EMAR immediately following administration. Notes in EMAR medications not administered (i.e., refused, etc.) and identifies reason." The policy also reflected that "Documents all held or refused medications on EMAR. Uses prudent professional judgement by informing Physician in a timely manner when medications held, refused, or otherwise unavailable for administration."

3. On 8/30/23 at 8:07 AM, during the morning medication pass, the surveyor observed the LPN#1 preparing five (5) medications which included Ex.Order 26.4(b)(1) [redacted] for Resident #56.

On 8/30/23 at 8:14 AM, the surveyor observed the LPN #1 crush four (4) of the five (5) medications together in a pouch and then poured the crushed medications into a 30 milliliter (ML) medication cup with applesauce. The LPN#1 then opened the Ex.Order 26.4(b) capsule and mixed the contents into the medication cup that had the four (4) medications and filled the medication cup with applesauce. The applesauce then turned a black

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color.

On 8/30/23 at 8:16 AM, the surveyor observed the LPN#1 approach the resident to administer the five (5) medications in the applesauce and the resident was shaking their head in the "no" direction. The LPN #1 explained that the applesauce contained the resident's medication and that it was important to take the medications. The LPN#1 scooped a spoonful of the applesauce and administered the spoonful to the resident. The resident took the spoonful and shook their head in the "no" direction repeatedly. The LPN#1 explained again the importance and told the resident there was just another spoonful left. The LPN#1 was unable to administer the remaining applesauce containing the medications.

Upon returning to the medication cart, the LPN#1 discarded the remaining applesauce in the garbage that was attached to the medication cart.

On 8/30/23 at 12:13 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the Infection Preventionist (IP) and Assistant Director of Nursing (ADON) were the staff educators for medication pass.

On 8/30/23 at 1:08 PM, the surveyor interviewed the Unit Manager (UM)/LPN who stated that when any medication had to be disposed there was a medication disposal system on each medication cart. The UM/LPN added that if the medication were a controlled medication, then the DON or ADON would be given the controlled medication for a witnessed destruction. The surveyor with the UM/LPN looked in the medication cart that the UM/LPN was using and were unable to find the

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medication disposal system in that medication cart. The UM/LPN stated that she would have to get one for the cart.

On 8/30/23 at 1:16 PM, the LPN#1 showed the surveyor that she had a medication disposal system on the medication cart that she was using. The LPN #1 stated that because the medications were crushed for Resident #56, she could throw them in the garbage that was attached to the medication cart.

On 8/31/23 at 9:30 AM, the surveyor interviewed the IP who stated that she was employed at the facility approximately less Ex.Order 26.4(b)(1) and could speak to medication pass techniques because she helped with orientation and educating the nurses on medication pass techniques. The IP stated that when the nurses had to dispose of a medication that was not a controlled medication then they would use the medication disposal system that was on each cart. The IP further explained that the safest method for medication disposal even if the medications were crushed was to use the medication disposal system.

On 9/1/23 at 9:38 AM, the surveyor interviewed the CP via the telephone who stated that the nurses were to use the medication disposal system when a medication needed to be discarded. The CP added that even if the medication was crushed that the medication disposal system should be used and thought there was one on each medication cart.

A review of the undated facility policy for "Discarding and Destroying Medications" provided by the DON reflected that

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"Non-controlled and Schedule V (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications."

4. On 8/28/23 at 11:42 AM the surveyor observed Resident #75 in bed, the surveyor attempted to interview the resident, but the resident was Ex.Order 26.4(b)(1) .

The surveyor reviewed the medical record for Resident #75.

A review of the resident's AR revealed diagnoses which included Ex.Order 26.4(b)(1)

A review of the admission MDS, an assessment tool used to facilitate the management of care, with an assessment reference date of Ex.Order 26.4(b)(1), reflected the resident had a BIMS score of Ex.Order 2 of 15, indicating that the resident had a Ex.Order 26.4(b)(1) .

A review of the August and September electronic medication records (EMAR) revealed a PO dated Ex.Order 26.4(b) for Ex.Order 26.4(b)(1) There was no documentation that the medication was administered.

A review of the vital sign recordings for the resident's Ex.Orde for Ex.Order 26.4(b)(1) had the following dates with Ex.Orde recordings that had a Ex.Orde less than

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Ex.Orde; on Ex.Order 26.4(b) at 5:26 PM Ex.Order 26.4, on Ex.Order 26.4(b) at 7:47 PM Ex.Order 26.4(b) and on 9/1/23 at 10:40 AM Ex.Order 26.4(b).

Further review of the August and September EMARs revealed a PO dated Ex.Order 26.4(b) for Ex.Order 26.4(b)(1) There was documentation on Ex.Order 26.4(b) that the Ex.Orde was Ex.Order 26.4 and on Ex.Order 26.4(b) the Ex.Orde was Ex.Order 26.4(b) and the Ex.Order 26.4(b)(1) medication was held. There was documentation on Ex.Order 26.4 that the Ex.Order 26.4(b)(1) medication was held but no documentation of the Ex.Orde results.

On 9/5/23 at 11:23 AM, the surveyor interviewed LPN #2 who stated that she was the medication nurse for Resident #75. The LPN #2 stated that the resident had been readmitted at the end of Ex.Order 26.4(b). The surveyor with the LPN#2 reviewed the EMAR regarding the PRN Ex.Order 26.4(b)(1) and the LPN#2 stated that if the resident's Ex.Orde was less than Ex.Order 1 then the Ex.Order 26.4(b)(1) should have been administered. The LPN#2 stated that she had not administered the Ex.Order 26.4(b)(1) because she had not had a Ex.Orde less than Ex.Order 9 for the resident. The LPN#2 acknowledged that the PRN Ex.Order 26.4(b)(1) had no documentation as being administered and also acknowledged that there was documentation of Ex.Order 1 less than Ex.Order 9. The LPN#2 also stated that the resident had no PO for a Ex.Orde to be obtained every Ex.Order 26.4(b)(1) was obtained twice a day for the medication Ex.Order 26.4(b)(1).

On 9/6/23 at 9:49 AM, the surveyor interviewed the DON who stated that she thought the PO for Ex.Order 26.4(b)(1) was a PRN PO and was allowed to be

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administered three times within a 24-hour period and that a [redacted] was not needed [redacted].

On 9/6/23 at 10:05 AM, the surveyor further interviewed the DON. The surveyor with the DON reviewed the EMAR for Resident #75. The DON acknowledged that the [redacted] was not administered when the Ex.Order 26.4(b)(1). The DON also acknowledged that when the [redacted] was taken for the [redacted] and was less than Ex.Order 26.4(b)(1) was held but there was no indication to administer the PRN [redacted] The DON acknowledged that the PO for PRN [redacted] should be clarified.

A review of the facility policy dated as reviewed 6/22/23 for "Medication Administration and Documentation" provided by the DON reflected that "It is the policy of this facility to ensure that Medication Administration and Documentation occurs in a timely and accurate manner." In addition, the policy reflected, "Monitors vital signs when appropriate prior to medication administration. Administers med according to parameters ordered by physician (if any)."

5. On 8/30/23 at 11:25 AM, the surveyor inspected the 3rd floor medication room refrigerator in the presence of Licensed Practical Nurse (LPN#1). The surveyor observed a narcotic lock box that contained five syringes of Ex.Order 26.4(b)(1) for Resident #88. The surveyor observed the narcotic box was affixed to the medication refrigerator, but the narcotic box was unlocked. The surveyor interviewed LPN#2 who

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acknowledge that the narcotic box was unlocked, and she further stated that it was the facility policy that all narcotics must be double lock.

A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included Ex.Order 26.4(b)(1) [redacted]

A review of the Order Summary (OS) (physician's order) dated Ex.Order 26.4(revealed a physician order (PO) for Ex.Order 26.4(b)(1) [redacted] A further review of the PO revealed that the medication was discontinued on Ex.Order 26.4(b)(

A review of the Ex.Order 26.4(b)(1) electronic Medication Administration Record (eMAR) revealed an order dated Ex.Order 26.4, for Ex.Order 26.4(b)(1) [redacted] hours as needed for Ex.Order 26.4(b)(1) ion with a discontinued date of Ex.Order 26.4(b)(.

On 3/30/23 at 12:30 PM, the surveyor inspected the 3rd floor medication room refrigerator narcotic box in the presence of LPN#1. LPN#1 acknowledge that the Ex.Order 26.4(b)(1) was discontinued and should be remove from active medication and will be destroyed per facility policy.

b). On 8/30/23 at 11:35 AM, the surveyor inspected the 2nd floor medication room

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refrigerator in the presence of LPN#2. The surveyor observed a narcotic lock box that contained twenty-six (26) capsules of [redacted] for Resident #64. The narcotic box was observed affixed to the medication refrigerator, but the narcotic box was unlocked.

The surveyor interviewed LPN#2 who acknowledge that the narcotic box was unlocked, and she further stated that it was the facility policy that all narcotics must be double lock.

A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses that included [redacted]

A review of the Order Summary Report (OSR) (physician's order) dated [redacted] revealed PO for [redacted] capsule by mouth two times a day for [redacted]

A review of the [redacted] eMAR revealed an order dated [redacted], for [redacted] times a day for [redacted] with a discontinued date of [redacted]

A review of a Progress Note dated [redacted] at 5:10 PM revealed that Resident #64 was discharged home.

On 3/30/23 at 12:30 PM, the surveyor inspected the 2nd floor medication room refrigerator narcotic box in the presence of LPN#2. LPN#2

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acknowledge that the [redacted] belonged to Resident #64 and that the resident was discharged from the facility. The surveyor observed LPN#2 place the [redacted] back in the narcotic box and then lock the box. LPN#2 stated that she will destroy the medication during shift change because she will need another nurse to witness the destruction.

On 8/31/23 at 1:00 PM, the surveyor discussed the above concerns with the Administrative team which included the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). There was no additional information provided.

A review of the facility's policy for Controlled Medications Accountability and storage that was dated 01/07/23 and was provided by the DON included the following:
"Narcotic ordered for residents are stored in a locked narcotic box of the medication cart. If the narcotic medication is to be refrigerated, the narcotic is stored in the locked box within the refrigerator. The refrigerator has a lock on the door as well."

A review of the facility's policy Medication Storage that was dated 05/26/23 and was provided by the DON included the following:
"4. Any discontinued medications should be removed from the refrigerator, med room or med cart and returned to pharmacy or discarded no later than 14 days."

A review of the facility's policy Discarding and Destroying Medications that was undated and was provided by the DON revealed the following:
"5 (c). Disposal of controlled substances must

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F 755	Continued From page 34 take place immediately (no longer than three days) after discontinuation of use by a resident." NJAC 8:39-11.2 (b), 29.2(a), 29.2 (d), 29.3(a)(5), 29.4(g)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observation on 8/30/23, the surveyor observed two (2) nurses administer medications to five (5) residents. There were 31 opportunities, and six (6) errors were observed which calculated to a medication administration error rate of 19.3%. This deficient practice was identified for two (2) of five (5) residents, (Resident #56 and #83), that were administered medications by one (1) of two (2) nurses that were observed. The deficient practice was evidenced by the following: 1. On 8/30/23 at 8:00 AM, during the morning medication pass, the surveyor observed the Licensed Practical Nurse (LPN #1) obtaining a Ex.Order 26.4(b)(1)) for Resident #56. The LPN#1 placed the [redacted] on the resident's [redacted]. The LPN #1 stated that this	F 759	I: IMMEDIATE ACTION LPN #1 responsible for Medication administration for residents #56 and # 83 was immediately in serviced on Medication administration, including [redacted] administration of medications with parameters, administration of crushed medications and Ex.Order 26.4(b)(1). II: IDENTIFICATION OF OTHERS All residents have the potential of being affected by the deficient practice. III: SYSTEMIC CHANGES On 9/11/23 LPN #1 was re in serviced on Medication Administration On 9/12/23 an in service for all nurses was conducted on Medication administration, including vital signs, medications with parameters, administration of crushed medications and transdermal patches. 9/11/23 Administrator and Director of	9/13/23

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F 759	Continued From page 35 was the best way to obtain the [redacted] because the resident was [redacted] The LPN#1 then stated that she received an error indication on the digital [redacted] machine, the surveyor observed her reposition the [redacted] on the same area and immediately restarted the [redacted] machine. The LNP#1 then stated that she had obtained a [redacted] of [redacted] and a [redacted] The LPN#1 added that the resident's [redacted] and would check the [redacted] again later. After removing the [redacted] cuff, the LPN#1 asked the resident if he/she wanted the [redacted] the resident shook their head in the "yes" direction. The LNP#1 explained to the surveyor that the resident did not always like the [redacted] because it turned the applesauce black and would refuse to take it. On 8/30/23 at 8:07 AM, the surveyor observed the LPN#1 preparing five (5) medications which included one [redacted] for Resident #56. On 8/30/23 at 8:14 AM, the surveyor observed the LPN #1 crush four (4) of the five (5) medications together in a pouch and then poured the crushed medications into a 30 milliliter (ML) medication cup with applesauce. The LPN#1 then opened the [redacted] capsule and mixed the	F 759	Nursing reviewed the policy and procedure for Medication administration, no changes. IV: QA MONITORING Director of nursing or designee will observe 2 nurses from different shifts for medication administration, weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters All findings will be reviewed at the Quality Assurance meeting x 2 quarters V: PERSON RESPONSIBLE: Director of Nursing, ADON	

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contents into the medication cup that had the four (4) medications and filled the medication cup with applesauce. The applesauce then turned a black color.

On 8/30/23 at 8:16 AM, the surveyor observed the LPN#1 approach the resident to administer the five (5) medications in the applesauce and the resident was shaking their head in the "no" direction. The LPN #1 explained that the applesauce contained the resident's medication and that it was important to take the medications. The LPN#1 scooped a spoonful of the applesauce and administered the spoonful to the resident. The resident took the spoonful and shook their head in the "no" direction repeatedly. The LPN#1 explained again the importance and told the resident there was just another spoonful left. The LPN#1 was unable to administer the remaining applesauce containing the medications.

Upon returning to the medication cart, the LPN#1 discarded the remaining applesauce and stated that the resident had swallowed more than half of the applesauce, so she felt that the resident had received the medications. The LPN#1 then indicated on the electronic administration record (EMAR) that the resident had received the five (5) medications.

At that time, the LPN#1 was unable to verify that the complete dose of each of the five (5) medications was received. The LPN#1 stated that she should have used less applesauce. (ERROR #1, #2, #3, #4, #5)

The surveyor reviewed the medical record for Resident #56.

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F 759	Continued From page 37 A review of the resident's Admission Record (AR) revealed diagnoses which included Ex.Order 26.4(b)(1) [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of Ex.Order 26.4(b)(1), reflected the resident had a brief interview for mental status (BIMS) score of Ex.Order 26.4(b)(1) out of 15, indicating that the resident had Ex.Order 26.4(b)(1) A review of the Order Summary Report revealed physician orders (PO) for the following: 'Ex.Order 26.4(b)(1) [redacted] 'Ex.Order 26.4(b)(1) [redacted] Ex.Order 26.4(b)(1) [redacted] A review of the EMAR revealed consistency with the above POs.	F 759		

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On 8/30/23 at 12:13 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the Infection Preventionist (IP) and Assistant Director of Nursing (ADON) were the staff educators for medication pass.

On 8/30/23 at 1:08 PM, the surveyor interviewed the Unit Manager (UM)/LPN who stated that when the nurses had to crush medications that they should be crushed individually. The UM/LPN also stated that if crushed medications were all mixed in the same applesauce or pudding then the resident had to take the entire contents. The UM/LPN added stated that if the resident refused to finish the applesauce or pudding that contained all the medications then there was no way to know how much of the medications that the resident received. The UM/LPN stated that a Ex.Orde [redacted] had not sounded accurate and would retake the Ex.Order to be sure. The UM/LPN added that if the Ex.Order 26.4(b)(1) was a true reading than the physician should be called. The UM/LPN added that she would not administer any medication if she had not thought the Ex.Order was accurate.

On 8/31/23 09:30 AM, the surveyor interviewed the IP who stated that she was employed at the facility approximately Ex.Order 26.4(b)(1) and could speak to medication pass techniques because she helped with orientation and educating the nurses on medication pass techniques. The IP stated that the nurses should not crush all the medications together because if the resident were to refuse to take all the applesauce or pudding that the medications were mixed in then there would be no way to determine which medication the resident had not received. The IP added that if a resident took some of the

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crushed medication there was no way to determine the actual dose received. The IP added that the nurse would have to document that the medication was refused because the whole dose would not have been administered and the physician should be notified. The IP also stated that the nurses should try to figure out why the resident was refusing medications and put interventions in place such as changing the medication if the taste were an issue or possibly changing the time. The IP then stated that crushing medications required a physician's order and usually would populate in the EMAR to crush the medications so that all the nurses were aware. In addition, the IP stated that Ex.Order 26.4(b) [redacted] had not sounded accurate and would recommend retaking Ex.Order 26.4(b)(1) was accurate than the physician should be called.

On 8/31/23 at 11:30 AM, the IP provided the surveyor with an example of an unsampled residents electronic record that indicated "Special Instructions: crush meds per resident request" to explain how there was a section to populate that indicated that the resident took their medications crushed. A review of Resident #56's electronic record had not indicated special instructions.

In addition, the IP provided the surveyor with a "Medication Pass Audit Tool" dated Ex.Order 26.4(b) [redacted] for LPN #1 completed by the Consultant Pharmacist (CP) which revealed that there were areas indicating a "No", which meant that the technique was not performed appropriately, which included for the "Technique Assessment: Medications via Gastric Tube" that "Administers each medication individually." was not performed correctly and there was a handwritten note that this was "discussed."

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On 8/31/23 at 2:07 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, ADON and IP to review the medication observation results. The IP stated that when a medication pass audit was performed if there were indications that proper procedures were not followed then another observation and in servicing would be followed up. The DON stated that she would check if there were any other medication observations performed for LPN #1.

On 9/1/23 at 8:58 AM, the DON provided the surveyor with an "In-service on medication pass" dated Ex.Order 26.4(b) completed by the ADON and signed by LPN #1 was performed and a "Competency Validation: Medication Pass" was completed by the ADON on Ex.Order 26.4(b) that indicated the LPN#1 "Meets Standard" for all the "Performance Criteria." In addition, the DON provided a "Medication Observation Form" dated Ex.Order 26.4 for LPN #1 completed by the provider pharmacy which revealed that there was zero (0) % error rate.

On 9/1/23 at 9:38 AM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone who stated that she had been the consultant for the facility for Ex.Order 26.4(b)(1). The CP stated that she had performed medication observations with the nurses and verified that she used a "Medication Pass Audit Tool" but was unable to speak to the actual form that she had completed for LPN#1. The CP stated that she would add to the form "Discussed "tips & tricks" for med pass observation by Department of Health (DOH), etc." because as she performed the medication observation, she would review different areas to help the nurses understand

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what the correct procedure that should be done during the medication pass. The CP stated that medications should be crushed separately unless there was a PO and the reason for crushing the medications separately was because if a resident refused to finish the vehicle that the medications were mixed in then the nurse would have no way of knowing the actual dose the resident received. The CP added that if a resident was refusing a medication or was unable to receive the entire dose then the physician should be notified, and the nurses should review the possible reason the resident was refusing to possibly make a change. The CP added that the completed "Medication Pass Audit Tool" was left with the DON and if there were issues, she would review them, and the DON would decide the next step.

A review of the facility policy dated as reviewed 6/22/23 for "Medication Administration and Documentation" provided by the DON reflected that "The EMAR is the form onto which all medication orders are transcribed from physician electronic orders, from which medications are poured and administered and on which medication doses are documented." In addition, the policy reflected, "Obtains orders for crushing of medications as appropriate/necessary as per manufacturer's directions and crushes medications individually prior to administration." Also, "Administers full dose of medication to resident via correct route."

2. On 8/30/23 at 8:20 AM, during the morning medication pass, the surveyor observed the LPN #1 preparing six (6) medications which included a Ex.Order 26.4(b)(1) for Resident #83. The LPN#1 removed a Ex.Order 26.4(b)(1) from the medication cart and stated that Ex.Order 26.4(b)(1) was a

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house stock medication, meaning that the facility provided the medication and was an over the counter (OTC) medication.

On 8/30/23 at 8:35 AM, the surveyor observed the LPN#1 apply the Ex.Order 26.4(b)(1) to the resident's Ex.Order 26.4(b)(1).

On 8/30/23 at 8:41 AM, upon returning to the medication cart, the surveyor with the LNP#1 reviewed the EMAR regarding the Ex.Order 26.4(b)(1) The surveyor asked the LPN#1 if Ex.Order 26.4(b)(1) on the EMAR for "Ex.Order 26.4(b)(1) was the same as the Ex.Order 26.4(b)(1) that she had applied to the resident's Ex.Order 26.4(b)(1). The LPN#1 stated that she thought the Ex.Order 26.4(b)(1) was a house stock medication and thought she was correct. The LPN#1 then looked in the medication cart and removed the box that she had taken the Ex.Order 26.4(b)(1) from. The surveyor with the LPN#1 observed a label on the Ex.Order 26.4(b)(1) box which revealed the name of an unsampled resident. The LPN#1 stated that the Ex.Order 26.4(b)(1) that she had removed was from the unsampled resident's box of Ex.Order 26.4(b)(1) and thought there was another box that contained the house stock Ex.Order 26.4(b)(1). The LPN#1 looked through the medication cart and was unable to find a box containing Ex.Order 26.4(b)(1) The LPN#1 stated that she would have to call the physician. (ERROR #6)

The surveyor reviewed the medical record for Resident #83.

A review of the AR revealed that the resident had diagnoses which included Ex.Order 26.4(b)(1) .

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A review of the admission MDS, an assessment tool used to facilitate the management of care with an assessment reference date of Ex.Order 26.4(b)(1), reflected the resident had a BIMS score Ex.Order 26 out of 15, indicating that the resident had Ex.Order 26.4(b)(1)

A review of the Order Summary Report revealed a PO dated Ex.Order 26.4(b) with for Ex.Order 26.4(b)(1) apply to Ex.Order 26 one time a day for Ex.Order 26 apply for Ex.Order 26.4(b)(1)."

A review of the EMAR revealed a PO with a start date of Ex.Order 26.4(b) for "Ex.Order 26.4(b)(1) apply to Ex.Order 26.4(b)(1) a day for Ex.Order 26 apply Ex.Order 26.4(b)(1)

On 8/30/23 at 12:11 PM, the DON provided the surveyor with the facility "Over the Counter (OTC) List." The DON explained that the list indicated which medications the provider pharmacy would know not to send to the facility if there was a PO and the facility would provide.

A review of the "OTC List" reflected for Ex.Order 26.4(b)(1) that the provider pharmacy "Do NOT Send" and that the facility provided that medication.

On 8/30/23 at 12:13 PM, the DON stated that a med error report for Resident #86 was done. The DON acknowledged that Ex.Order 26.4(b)(1) was a house stock medication and was ordered for Resident #83 and that the LPN#1 had administered Ex.Order 26.4(b)(1) that was obtained from an unsampled resident's prescription. The DON added that the physician was notified.

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F 759	Continued From page 44 A review of the facility policy dated as reviewed 6/22/23 for "Medication Administration and Documentation" provided by the DON reflected that "Assures the 5 rights: Compares the medication name, strength, route and dosage schedule on the medication administration record against the prescription label, Always check three times prior to administration of medication." NJAC 8:39-11.2(b), 27.1(a), 29.2(a)(d)	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		9/13/23

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F 761	Continued From page 45 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to (a). properly label, store and dispose of medications in two (2) of five (5) medication carts inspected, b). failed to secure two (2) of two (2) narcotic lock boxes in 2 of 2 medication refrigerators inspected, and c). failed to secure medications in one (1) of five (5) and in one (1) of four (4) treatment carts observed. This deficient practice was evidenced by the following: a). On 8/30/23 at 11:10 AM, the surveyor inspected the 3rd floor medication cart A in the presence of Licensed Practical Nurse (LPN#1). The surveyor observed an unopened and undated bottle of Xalatan eye drops (medication for pressure in the eyes), an opened bottle of Xalatan eye drops with an opened date of 7/7/23 with an expiration date of 8/20/23, and an opened bottle of Dorzolamide eye drops (pressure in the eyes) with an opened date of 7/20/23 and was expired. The surveyor interviewed LPN#1 who stated that both Xalatan and Dorzolamide were outdated and should have been removed from the medication cart. LPN#1 also stated that a bottle of unopened and undated Xalatan eye drops should have been stored in the medication refrigerator. On 8/30/23 at 11:20 AM, the surveyor inspected the 3rd floor medication cart B in the presence of LPN#2. The surveyor observed an opened and undated bottle of LPS (protein supplement)	F 761	I: IMMEDIATE ACTION The expired eye drops were removed and disposed immediately. The undated bottle of liquid protein and the unopened eye drops container (which should have been refrigerated) were discarded immediately. New products ordered from pharmacy and received/replaced. Controlled medications for Resident #88 and Resident # 64 which were previously discontinued, were immediately removed from the refrigerator and disposed as per guidelines. The narcotic boxes in the refrigerators were locked as per guidelines. LPN #1 and LPN #2 and Nurse #1 were in serviced on 9/7/23 on Medication storage, labeling and disposal. II: IDENTIFICATION OF OTHERS All residents have the potential of being affected by the deficient practice. III: SYSTEMIC CHANGES On 9/12/23 an in service for all nurses was conducted on Medication storage, labeling and disposal. On 9/12/23 Administrator and Director of Nursing reviewed the policy and procedure for Drug storage, no changes were made. On 9/13/23 all medication carts, treatment carts, medication rooms and medication refrigerators were checked for proper storage, labeling and disposal.	

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F 761	Continued From page 46 solution. The surveyor reviewed the manufacturer's instructions on the bottle of LPS in the presence of LPN#2. After reviewing the manufacturer's instructions, LPN#2 stated that once opened a bottle of LPS solution have a 60-day expiration date. LPN#2 acknowledge that the bottle of LPS solution was undated and that when bottle was opened it should have been dated. A review of the Manufacturer's Specifications for the following medications revealed the following: 1. Xalatan eye drops once opened have an expiration date of 42-days. 2. Dorzolamide eye drops once opened have an expiration date of 28-days. 3. LPS solution once opened have an expiration date of 60-days. 4. Unopened Xalatan eye drops should have been stored in a refrigerator. b). On 8/30/23 at 11:25 AM, the surveyor inspected the 3rd floor medication room refrigerator in the presence of LPN#2. The surveyor observed a narcotic lock box that contained five syringes of Ex.Order 26.4(b)(1) [redacted] The narcotic box was affixed to the medication refrigerator, but the narcotic box was unlocked. The surveyor interviewed LPN#2 who acknowledge that the narcotic box was unlocked, and she further stated that it was the facility policy that all narcotics must be double lock. On 8/30/23 at 11:35 AM, the surveyor inspected the 2nd floor medication room refrigerator in the presence of LPN#3. The surveyor observed a	F 761	IV: QA MONITORING Director of nursing or designee will check the medication room and medication carts for proper drug storage, labeling and disposal, weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters Director of nursing or designee will check medication room on both units to ensure the narcotic box in the refrigerator is locked and that there are no controlled medications stored in the box if the order was discontinued, weekly x 4 weeks then monthly x 2 months, then quarterly x 2 quarters All findings will be reviewed at the Quality Assurance meeting x 2 quarters V: PERSON RESPONSIBLE: Director of Nursing, ADON	

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F 761	Continued From page 47 narcotic lock box that contained twenty-six (26) capsules of Ex.Order 26.4(b)(1) capsules. The narcotic box was observed affixed to the medication refrigerator, but the narcotic box was unlocked. The surveyor interviewed LPN#3 who acknowledge that the narcotic box was unlocked, and she further stated that it was the facility policy that all narcotics must be double lock. c). On 8/28/23 at 11:35 AM, the surveyor while conducting initial tour observed a 2nd floor medication cart outside of room [redacted], that was left unattended and contained an unused insulin syringe, glucose test strips, blood glucose monitor and a vial of Humalog insulin that were left unsecured on top of the medication cart. The surveyor observed no residents in the vicinity of the medication cart. The surveyor waited for the nurse to returned to the cart which was approximately 4-minutes after the medication cart was observed. The surveyor interviewed LPN#4 who acknowledge that it was her medication cart. She further acknowledges that she left the cart unattended with medications and medical supplies left in an unsecured area. LPN#2 also stated that it's the facility policy when a medication cart is left unattended that all medications and medical supplies should be left in a lock and secured area. On 8/31/23 at 1:00 PM, the surveyor discussed the above concerns with the Administrative team which included the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). There was no additional information provided.	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315198	A. BUILDING _____ B. WING _____	C 09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

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F 761	Continued From page 48	F 761		

A review of the facility's policy for Medication Storage that was dated 05/26/23 and provided by the DON that included the following:
"2. Any meds that will be expiring should be removed before expiration date. If pending expiration, will determine if supply will be completed before expiration date."

A review of the facility's policy for Controlled Medications Accountability and storage that was dated 01/07/23 and provided by the DON included the following:
"Narcotic ordered for residents are stored in a locked narcotic box of the medication cart. If the narcotic medication is to be refrigerated, the narcotic is stored in the locked box within the refrigerator. The refrigerator has a lock on the door as well."

A review of the facility's policy for Medication Administration and Documentation Policies, Procedures and Information that was dated 7/1/22 and provided by the DON included the following:
"6. The medication cart must be locked when out of nurse's view."

2. On 09/05/23 at 01:33 PM, ADON/RN (Nurse #1) told the surveyors she was ready to do the treatment pass. The treatment cart was right outside the resident's room, and there was a computer on top of the treatment cart. The Nurse

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F 761	Continued From page 49 #1 read the following treatment: "Ex.Order 26.4(b)(1) [redacted] AND Ex.Order 26.4(b)(1) [redacted]." On 9/05/23 at 01:37 PM, the Nurse #1 squeezed Ex.Order 26.4(b) into the two (2) medicine cups and one (1) medicine cup for Ex.Order 26.4(b)(1), then checked the order from the computer. On 9/05/23 at 01:47 PM, the Nurse #1 entered the resident's room, put on gloves, and put the treatment supplies on the overbed table. Nurse #1 returned to the treatment cart to get the two medicine cups that contained Ex.Order 26.4(b)(1) and Ex.Order 26.4(b) in each cup outside the resident's room. The Nurse #1 returned to the resident's room but left one medicine cup with Ex.Order 26.4(b) on top of the treatment cart outside. The surveyor got the attention of the Nurse #1 regarding the medication left on top of the treatment cart. The Nurse #1 stated that she forgot but did not comment further. NJAC: 8:39-29.4 (a) (h) (d)	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062018	A. BUILDING: _____ B. WING _____	C 09/06/2023

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ADROIT CARE REHABILITATION AND NURSING CEN	1777 LAWRENCE STREET RAHWAY, NJ 07065

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S 000	Initial Comments STANDARD AND COMPLAINT STATE SURVEY - 9/6/23 C#: NJ00155894; NJ00162775; NJ00166081 SAMPLE SIZE: 21 CENSUS: 104 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following:	S 560	ELEMENT: 1 Immediate Action: 1. The Administrator and Director of Nursing met with the Staffing Coordinator to determine current staffing vacancies in the nursing department to ensure accuracy of facility needs. 2. The facility has reviewed current	9/7/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/19/23

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S 560	Continued From page 1 Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of the resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including	S 560	salaries in comparison to other facilities in the immediate area to ensure salary competitiveness within the community. 5. Nursing Administration is available for interviews, hiring and training as needed to ensure all potential candidates are interviewed, evaluated and offered positions if appropriate. (Ongoing) 6. The facility continues to offer incentives including referral bonuses and other incentives. 7. The facility advertises on various platforms such as social media, posted flyers in various community establishments, colleges and schools. We have partnered with C.N.A. schools, hung banners across facility proper to enhance our recruitment efforts. We have encouraged word of mouth referrals to employees and the community. (Ongoing) 8. The facility works with a full-time recruiter whose sole responsibility is to recruit nurses and C.N.A.s. ELEMENT 2: Identification of Others: All residents have the potential to be affected by this deficient practice. No residents were affected by this deficient practice. ELEMENT 3: Systemic Changes 1. The Administrator, Director of Nursing, Human Resource Director have reviewed the state staffing ratios with the Staffing Coordinator to ensure meeting the state required ratios is the primary focus for staffing the facility. 2. The Staffing Coordinator was instructed to notify the Director of Nursing and/or the Administrator when staffing	

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S 560	Continued From page 2 certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day on which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" 1. The week of Complaint staffing from 05/22/2023 to 05/28/2023, the facility was deficient in CNA staffing for residents on 5 of 7-day shifts as follows: - On 05/22/23 had 10 CNAs for 103 residents on the day shift, which required at least 13 CNAs. - On 05/23/23 had 11 CNAs for 100 residents on the day shift, which required at least 12 CNAs. - On 05/24/23 had 10 CNAs for 100 residents on the day shift, which required at least 12 CNAs. - On 05/25/23 had 8 CNAs for 100 residents on the day shift, which required at least 12 CNAs. - On 05/28/23 had 12 CNAs for 103 residents on	S 560	ratios are not being met so they can lend assistance in fulfilling those ratios. 3. Human Resource Director will complete exit interviews for all nursing employees who have vacated their positions in an attempt to address any issues which could be affecting retention of employees. (Ongoing) 4. An Orientation will be scheduled bi-weekly to ensure that all potential candidates for employment will have opportunities to complete the orientation as soon after accepting a facility offer. Element 4: Quality Assurance 1. The staffing coordinator or designee will compile a tracking log that will be maintained for all communication with referrals, applicants, interviews, newly hired, orientation completion and success of recruitment efforts and will be reviewed monthly by Director of Nursing, Administrator and Human Resource Director. 2. All findings will be reviewed by the Quality Assurance Team at least quarterly, and changes made as needed to improve facility ratios. V. Responsibility: Administrator, Director of Nursing and Human Resource Director	

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S 560	Continued From page 3 the day shift, which required at least 13 CNAs. 2. For the 2 weeks of staffing prior to the survey from 08/13/2023 to 08/26/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: - On 08/13/23 had 8 CNAs for 105 residents on the day shift, which required at least 13 CNAs. - On 08/13/23 had 9 total staff for 105 residents on the evening shift, which required at least 10 total staff. - On 08/14/23 had 11 CNAs for 105 residents on the day shift, which required at least 13 CNAs. - On 08/15/23 had 10 CNAs for 105 residents on the day shift, which required at least 13 CNAs. - On 08/16/23 had 11 CNAs for 105 residents on the day shift, which required at least 13 CNAs. - On 08/17/23 had 11 CNAs for 105 residents on the day shift, which required at least 13 CNAs. - On 08/18/23 had 12 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 08/19/23 had 8 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 08/20/23 had 7 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 08/21/23 had 9 CNAs for 104 residents on the day shift, which required at least 13 CNAs.	S 560		

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S 560	Continued From page 4 - On 08/22/23 had 11 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 08/23/23 had 10 CNAs for 103 residents on the day shift, which required at least 13 CNAs. - On 08/24/23 had 11 CNAs for 101 residents on the day shift, which required at least 13 CNAs. - On 08/25/23 had 11 CNAs for 101 residents on the day shift, which required at least 13 CNAs. - On 08/26/23 had 8 CNAs for 101 residents on the day shift, which required at least 13 CNAs. 3. For the week of staffing from 05/22/2022 to 08/28/2022 The facility was deficient in CNA staffing for residents on 4 of 7 day shifts, deficient in total staff for residents on 2 of 7 evening shifts, deficient in CNSs to total staff on 1 of 7 evening shifts, and deficient in total staff for residents on 1 of 7 overnight shifts as follows: - On 05/22/22 had 6 CNAs for 82 residents on the day shift, which required at least 10 CNAs. - On 05/23/22 had 9 CNAs for 82 residents on the day shift, which required at least 10 CNAs. - On 05/26/22 had 7 total staff for 82 residents on the evening shift, which required at least 8 total staff. - On 05/27/22 had 9 CNAs for 82 residents on the day shift, which required at least 10 CNAs. - On 05/28/22 had 7 CNAs for 82 residents on the day shift, which	S 560		

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S 560	Continued From page 5 required at least 10 CNAs. - On 05/28/22 had 6 total staff for 82 residents on the evening shift, which required at least 8 total staff. - On 05/28/22 had 2 CNAs to 6 total staff on the evening shift, which required at least 3 CNAs. - On 05/28/22 had 5 total staff for 82 residents on the overnight shift, which required at least 6 total staff. On 9/06/23 at 1:20 PM, the surveyor discussed the staffing ratios concerns with the Administrator and Director of Nursing and did not comment further.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315198 Y1	A. Building B. Wing Y2	9/25/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0641	Correction	ID Prefix F0695	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.25(i)	Completed
LSC	09/11/2023	LSC	09/11/2023	LSC	09/11/2023
ID Prefix F0755	Correction	ID Prefix F0759	Correction	ID Prefix F0761	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(f)(1)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	09/13/2023	LSC	09/13/2023	LSC	09/13/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/6/2023	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315198		9/25/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 09/11/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315198	A. BUILDING **01** B. WING _____	**09/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	**1777 LAWRENCE STREET** **RAHWAY, NJ 07065**

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E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 08/30/23. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/30/23 and the facility and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Adroit Care Rehabilitation and Nursing Center is a three-story building with a partial basement that was built in 1983. It is composed of Type II construction. The facility is fully sprinklered and is divided into eight smoke compartments. The generator powers 100% of the building per the Maintenance Director. The number of occupied beds was 106 out of 122. .	K 000		
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.	K 225		9/7/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/19/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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ADROIT CARE REHABILITATION AND NURSING CENTER	**1777 LAWRENCE STREET** **RAHWAY, NJ 07065**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 225	Continued From page 1 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure fire rated door assemblies for stairway exit doors were equipped with fire exit hardware and the releasing mechanism did not require more than one releasing operation in accordance with NFPA 101 (Life Safety Code) 2012 Edition Section 7.2. This deficient practice had the potential to affect all 106 residents. Findings include: An observation on 08/30/23 at 9:30 AM revealed the exit stairwell door, located by the Lobby, did not have the required fire exit hardware. The door had a standard door handle lever that required more than one releasing operation to open the door. The standard door lever handle hardware on the door was damaged and missing parts. During an interview at the time of the observation the Maintenance Director confirmed the door was equipped with a standard door handle lever and stated the facility was aware the door required fire exit hardware and planned to replace it. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 225	K225 I. Immediate Correction a. Facility installed proper fire exit hardware and releasing mechanism in accordance with NFPA 101 (2012, Sec. 7.2) for the identified door to stairwell, located in the lobby. Date Completed: 9/7/23 II. Identification of Others a. The facility respectfully states that all residents have the potential to be affected by this practice, however no residents were involved in this deficiency. b. The maintenance staff will inspect other areas in the facility to ensure all fire rated door assemblies for stairway exits are equipped with proper fire exit hardware and releasing mechanisms Any findings will be corrected. III. Systemic Changes a. Maintenance staff were in serviced on the proper applicable fire exit hardware and releasing mechanisms Date Completed: 9/7/23 IV. QA Monitoring a. The Director of Maintenance will conduct monthly audits for 6 months to ensure all fire rated door assemblies for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315198	A. BUILDING **01** B. WING _____	**09/06/2023**

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K 225	Continued From page 2	K 225	stairway exits are equipped with proper fire exit hardware and releasing mechanisms d. Audit findings will be presented to the quality assurance committee quarterly x 2.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: . Based on observations and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect all 106 residents. Findings include: An observation on 08/30/23 at 9:51 AM of the	K 372	K372 I. Immediate Correction a. Facility will install proper fire rated sealer to ensure penetrations in smoke barriers are protected by a system or material capable of restricting the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012, Sec. 8.5.6.1 and 8.5.6..2) for the identified areas of concern Date to be Completed: 10/25/23 II. Identification of Others	10/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315198	A. BUILDING **01** B. WING _____	**09/06/2023**

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K 372	Continued From page 3 smoke barrier, located inside Room 200, revealed an eight-inch unsealed gap above two pipe penetrations and the top of the wall in the Bathroom. An observation on 08/30/23 at 9:53 AM of the smoke barrier, located at the Day Room, revealed a two-inch unsealed gap along the top of the smoke wall, and a three-inch gap around conduit penetrations above the ceiling and decorative fireplace. An observation on 08/30/23 at 9:45 AM of the smoke barrier, located by Room 200, revealed a three-inch and twelve-inch unsealed gap along the top of the smoke wall above the smoke doors on both sides of the wall. An observation on 08/30/23 at 10:17 AM of the smoke barrier, located by Room 300, revealed a two-inch unsealed gap at the top of the wall and an unsealed three-inch gap around a conduit penetration above the ceiling and smoke doors. An observation on 08/30/23 at 10:20 AM of the smoke barrier, located inside Room 300, revealed a three-foot by one-foot unsealed gap above the ceiling near the center of the wall and the top of the wall had an unsealed three-inch gap. During an interview at the time of observations, the Maintenance Director confirmed the unsealed openings and penetrations and stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers. NJAC 8:39-31.1(c), 31.2(e)	K 372	a. The facility respectfully states that all residents have the potential to be affected by this practice, however no residents were involved in this deficiency. b. The maintenance staff will inspect other areas in the facility to ensure penetrations in smoke barriers are protected by a system or material capable of restricting the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012, Sec. 8.5.6.1 and 8.5.6..2) Any findings will be corrected. Date to be Completed: 10/25/23 III. Systemic Changes a. Maintenance staff will be in serviced on the proper protection of penetrations in smoke barriers by a system or material capable of restricting the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012, Sec. 8.5.6.1 and 8.5.6..2) needed in the facility. IV. QA Monitoring a. The Director of Maintenance will conduct monthly audits for 6 months to ensure penetrations in smoke barriers are protected by a system or material capable of restricting the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012, Sec. 8.5.6.1 and 8.5.6.2) b. Audit findings will be presented to the quality assurance committee quarterly x 2.	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315198	A. Building 01 - MAIN BUILDING 01 B. Wing	10/25/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADROIT CARE REHABILITATION AND NURSING CENTER	1777 LAWRENCE STREET RAHWAY, NJ 07065

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0225	Correction Completed 09/07/2023	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 10/25/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
9/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO